Washington State Department of Social & Health Services
DDD Division of Developmental Disabilities

DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)

ADULT FAMILY HOME (AFH) PLACEMENT CHECKLIST

CLIENT'S NAME	DDD CASE NUMBER	CASE MANAGER'S NAME
ADULT FAMILY HOME (AFH) PROVIDER'S NAME	AFH TELEPHONE NUMBER (INCLUDE AREA CODE)	CELL PHONE/PAGER NUMBER
PROVIDER'S STREET ADDRESS		

PROVIDER ISSUES

1. Confirm the following per the Aging and Disability Services Administration (ADSA) AFH database or the DDD PQI CRM:

   Date: _____

   Current AFH license: ☐ Yes ☐ No
   Current DSHS AFH contract: ☐ Yes ☐ No
   DD Specialty designation: ☐ Yes ☐ No
   MH Specialty designation: ☐ Yes ☐ No
   Dementia Specialty designation: ☐ Yes ☐ No
   Conditions on license: ☐ Yes ☐ No If yes, specify:

   Licensed capacity: _____

2. Per the PQI staff or AFH provider: Number of current residents: _____

REFERRAL PROCESS

1. Release of Information form ..... Date: _____
2. Discuss placement need with AFH PQI staff ..... Date: _____
3. Discussion of individual's needs/referral with provider ..... Date: _____
4. Delivery of referral packet to provider (Form DSHS 10-232) ..... Date: _____
5. Preplacement visit ..... Date: _____
6. Is nurse delegation assessment required: ☐ Yes ☐ No

   If "Yes," give the date of the completed Registered Nurse assessment ..... Date: _____
   (**this must occur no later than the date of placement**)

   Is AFH trained and willing to do Nurse delegation: ☐ Yes ☐ No

SERVICE AUTHORIZATION

1. Date of current CARE assessment: _____ Daily Rate: _____

   ETR: ☐ Yes ☐ No Amount: _____
2. ☐ Basic Plus ☐ Non-Waiver

   POC includes AFH service: ☐ Yes ☐ No
3. Date of placement: _____
4. Start date of AFH payment authorization: _____
5. Date CCDB updated with new provider, address, assessment date: _____

COMMENTS

LEGAL REPRESENTATIVE	LEGAL STATUS	TELEPHONE NUMBER (INCLUDE AREA CODE)
CLIENT REPRESENTATIVE FOR NSA		TELEPHONE NUMBER (INCLUDE AREA CODE)

COMMENTS

CRM SIGNATURE	DATE

File in Client File